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ABSTRACT

The various specialty occupations dealing with the rehabilitation of the disabled, retarded, disfigured, emotionally disturbed and socially disadvantaged have for a number of years suffered a manpower shortage. Since rehabilitation clients are stigmatized as unpleasantly different, and dealing with them is therefore considered "dirty work," it has been difficult to recruit rehabilitation workers as agents of social control. Data from a sample of rehabilitation counselors show that even some of these workers agree that clients are physically unpleasant and persons who have a disability are over-represented in this occupational group. Data from a sample of college students reveal variations in possible acceptance of rehabilitation clients on the basis of sex, race and occupational values with females, Blacks and those with people-oriented values the most accepting. Implications of the interactions of the staff and client stigma for manpower recruitment in the field are discussed. (Author)

AGENTS OF SOCIAL CONTROL:

ISSUES IN REHABILITATION MANPOWER

by

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Paper presented at the American Sociological Association Meetings, New Orleans, Louisiana, August 29, 1972.

This paper was written in connection with larger studies on the Rehabilitation Occupations for the Disadvantaged and Advantaged. and Career Contingencies of the Rehabilitation Counselor, supported in part by the Rehabilitation Services Administration, Project Numbers RD-3240 and RD-1726. and Case Western Reserve University.

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Rehabilitation clients, as defined by current legislation, include the mentally retarded, ex-mental patients, the poor, the socially and culturally deprived, the deaf and others whose disability is relatively invisible, along with those whose problems are more exposed, the disfigured, blind, cerebral palsied, crippled, legless or armless individuals. Common to all accepted as clients, no matter how deviant from the cultural norm of youth, health, brains and good looks, is the notion that rehabilitation is possible. Various physical, emotional and practical services can be used to restore the individual to occupational functioning at some level, or at least to help him achieve relative self-sufficiency in daily living.

To accomplish these tasks, a wide array of occupations is required, involving medical, paramedical, social and psychological disciplines. Many professional as well as skilled and semi-skilled types of worker are used in rehabilitation, but these are not necessarily specialists in the field. For example, orthopedists, receptionists, plastic surgeons, nurses' aides, psychiatrists, office clerks, cooks or school teachers may all serve a potential rehabilitatee in some fashion. Although work in a rehabilitation setting may create a "specialized" career for incumbents of these occupational roles, these are not the traditional specialties in the rehabilitation field, for which extensive training support has been provided over the years. They are not included in this discussion of rehabilitation manpower since their work is not limited to the rehabilitation process alone.

Specialists in rehabilitation include a set of occupations at a professional or near-professional level whose main work responsibilities lie

with potential physical, social or psychic rehabilitatees. At the physician level, there is the physiatrist, specially trained to deal with neuromuscular, musculoskeletal and vascular disorders, with a view to restoration of maximum function to afflicted patients. Rehabilitation nursing is a similar area of specialization in the nursing field. Recreation therapists aim at physical and emotional rehabilitation through recreational activity; physical therapists claim domain over activities to restore gross motor functioning, while occupational therapists are involved in training and retraining the patient for a return to work. Specialists in orthotics and prosthetics have the job of fitting braces, artificial limbs and other devices to correct for bodily defects or losses. Speech pathologists and audiologists focus on problems of communication, including intelligible speech and methods of enhancing or substituting for hearing. Social workers in rehabilitation assist clients in managing multiple personal, social and adjustment difficulties, while rehabilitation psychologists are particularly concerned with patients' mental and emotional hang-ups. Finally, rehabilitation counselors are not only responsible for guiding clients back into employment, but more generally for managing the whole panoply of tests, treatment and training which prepare the rehabilitatee to "return to normal functioning in the society."

For a number of years there have been shortages of personnel in nearly all these categories, despite the fact that the Rehabilitation Services Administration of HEW has been subsidizing training in all the fields mentioned. As can be seen in Table 1, the number of workers in each occupation, as calculated for 1970, totaled more than 68,000. Considering unfilled jobs, turnover, and expansion, the estimate is that over 165,000, more than a 100 percent increase, will be needed in 1975.

Where these workers are to come from is problematic. Even with the general lack of jobs in a declining economy, even with thousands of college students unable to find suitable employment, there is a likelihood that these shortages will not readily be overcome. One reason is that almost all these occupations, as presently constituted, require some additional training above the baccalaureate, and this takes time and money. But a more cogent reason can be hypothesized, and that is - all these occupations require dealing with stigmatized individuals, and thus can be defined as "dirty work."

As has already been indicated, candidates for rehabilitation do not conform to the American cultural norm of youth, health, brains and good looks. In the words of Goffman, they possess a stigma, "an undesired differentness," "abominations of the body," or "blemishes of individual character."[1] A common reaction to stigmatized persons is avoidance. Those who fancy themselves normal may be shocked and troubled by the sight of the crippled or by interaction with the emotionally upset, and would rather steer clear of any contact. Accordingly, persons whose jobs require them to deal with the stigmatized and the damaged are viewed as doing society's "dirty work."

"Dirty work" was coined by E. C. Hughes to characterize required jobs in a society which by societal definition are unpleasant. The definition is in the "eyes of the beholder."[2] Some "dirty work" jobs can be ennobling, e.g. the work of Catholic orders with terminal cases.[3] Hughes first labelled as dirty work the humbler jobs--janitors, junkmen--and then the dirty work aspects of even prestigeful jobs, like the physician who must poke into the human body. Prison guards, hospital attendents, teachers of the retarded, workers in nursing homes for the aged, morticians, are members of occupational groups who must do work considered critical to the smooth operation of the social order, but relegated to back alleys, behind walls, out of sight--in a word,"dirty."

Paradoxically, the association of deviance with dirty work can bode ill for any work system concerned with human services. Particularly in institutions, the victim and his keeper are contaminated with the dirty label and are inclined to express their frustration and hostility on one another. This condition makes it difficult to recruit quality candidates and establish careers publicly accepted as professional. Yet at the same time, a purpose is served by isolating a portion of the population from the mainstream of society. It shelves a population segment some of whose members might surprisingly provide competition for scarce awards and legitimizes societal differentiation, the haves from the have nots. Of not the least importance is the creation of a multi-billion-dollar human service system,an integral component of the economy; and opportunities for the ruling elite as well as reformers to express their profound concern over the plight of the ill, poor, neglected, and downtrodden.

One reason for the elaborate structure of rehabilitation services today was the clamor of legless and armless war veterans in the 20's for consideration. The movement spread in the 1940's, and today the categorical disorders such as the blind and deaf have organized lobbies to push for expanded legislation in their behalf. The public campaigns for Aid-to-the-Handicapped, complete with exhortations to hire, appeals to humanitarianism and good business, and photos of appealing youngsters in braces or solid-citizen types with crutches represent one method of handling the pressures to integrate the disabled, the physically or emotionally disadvantaged into the social structure.

This is counterbalanced by threat approaches to fund raising. Most mass media campaigns exhort the viewer or listener to give money by playing

on fear: "Mental illness knows no class or economic barrier. It can strike in your family." By giving money, the benefactor is absolved of responsibility to tackle the causes or consequences of the problem. These are some of the ambiguities and paradoxes related to occupational identities and roles in the rehabilitation field.

Finally, the aura of government support and public backing for compassionate treatment of disability does not over-ride the transferred stigma attached to those who must actually do the "dirty" job of dealing with deviants.

Even in periods of high unemployment, there are often labor shortages of the specially skilled and those needed for the most-avoided dirty work. Rehabilitation occupations fall simultaneously into both categories, and this, it can be argued, explains much of the manpower problem in the field.

To check the extent to which avoidance of work with the stigmatized might affect rehabilitation manpower, data from two studies are analyzed. The first is a survey of all rehabilitation counselors graduating from training in the spring of 1965 and all rehabilitation counselor practitioners in the field during the following year. The second study is a 1970 survey of students in a midwestern metropolitan junior college and state university, selected from social science classes. Thus there is available for analysis a set of those who have already made a selection of a career in one rehabilitation occupation, plus a group who might be considered possible candidates for recruitment into such a career.[4]

In a sequence of 17 items about various aspects of their work, the rehabilitation counselors in the first study were asked to react to the statement, "Rehabilitation counselors are required to deal with physically unpleasant people." (Table 2) Among the just graduating counselors, almost a third

agreed, while only about 1 in 5 counselors already on the job expressed a similar opinion. Perhaps those most repelled do not stay in the field, or perhaps the job changes their feelings toward the client, or perhaps some are never called upon to deal with the physically deformed in person. The data do not show the more likely alternative. Yet, about two-thirds of both neophytes and old hands agreed to the statement that "Work as a rehabilitation counselor is often emotionally exhausting," suggesting the commonly felt strain of dealing with stigmatized people in trouble. Only 32 percent of the employed counselors but 64 percent of the new trainees believed that "Most people would rather not be around anyone who is noticeably disabled," again indicating a change in views among those with more time and investment in rehabilitation.

At least a partial explanation for persons entering or remaining in the rehabilitation field under these circumstances is their own personal experience with a stigma. Twenty-three percent of the graduating students themselves suffered from some personal disablement--blindness, deafness, loss of limb, partial paralysis, or some less handicapping condition. Twenty-five percent had intimate knowledge of such ailments from some experience in their immediate families, among parents, siblings, spouses or children. Less than 30 percent had no experience with disability, either with respect to self, families or friends.

As for the already employed counselors, the picture was somewhat different. The practitioners were asked about their contact with disability prior to entering the field. Those with a personal disability constituted 21 percent of the group and 22 percent had an experience in their families, but 69 percent had had no direct contact with disablement befo· their employment in rehabilitation work.

The second study of a 1970 college sample of students attending social science classes was selected as a potential rehabilitation manpower pool, on the datum that 76 percent of the rehabilitation counselors studied earlier had majored in the social sciences. This generation of students, not oriented to the rehabilitation field, was largely unwilling to work with stigmatized persons. When asked if they would accept a job, assuming proper training, involving service to a list of possible clients--the mentally retarded, aged, disabled, delinquent or disturbed--from 68 percent to 78 percent said "no." Combining these various categories produced an index of willingness to work with at least one type of rehabilitation client; 60 percent could be classified as willing to do so, and 40 percent as rejecting the notion. Exploration of the correlates of these choices indicates some of the current issues with a bearing on manpower shortages in the field.

First there are distinct race-sex differences in rehabilitation client rejection rates. Women are less likely to reject such clients than men, and Blacks less likely than whites (Table 3). Only 42 percent of the white male students would be willing to work with any type of rehabilitation case, as compared to 60 percent of the Black male students. Differences between women students by race are less marked: 71 percent of the white females and 75 percent of the Black females would accept working with rehabilitation clients. The notion that those who have themselves suffered stigma are likely or more pressed to work with the stigmatized was suggested by the over-representation of the disabled among working rehabilitation counselors. Women and Blacks, who still suffer from social and cultural denigration, are less likely to rule out rehabilitation employment than the relatively advantaged whites and males.

This explanation is reinforced by an examination of the relationship between rehabilitation client acceptance and expected career lines (Table 4). Students planning a work life in science, engineering, business or public administration, traditionally white male careers, largely reject rehabilitation work; 50 to 75 percent falling into this category. Students expecting to go into social work, nursing or education, traditionally female occupations, and also among the few professional level jobs open to Blacks in the past, are more likely to be accepting of rehabilitation employment; only 12, 18, and 38 percent reject this type of client.

To explore further this rejection phenomenon, three types of occupational values suggested by Rosenberg[5]--Self-Expression, People-Oriented, and Extrinsic--were examined, along with a separate item specifically tapping attitudes to easy, non-challenging work (Table 5). It is apparent that persons who give preference to variables extrinsic to job content, such as high earnings and social prestige, largely reject rehabilitation clients: 62 percent would be unwilling to work with them, although the number who express this view is small. On the other hand, students who value self-expression on the job, the opportunity to use their talents and be creative and original, also tend to reject rehabilitation work beyond the group average, although less markedly than the extrinsic-oriented. Forty-eight percent of these would prefer not to work with rehabilitation cases.

As might be expected, the most open to this type of client are students who voice people-oriented values. Those who want to work with people and seek an opportunity to help others in their careers are in the main willing to accept rehabilitation work: only 26 percent reject this type of client. Perhaps the adjective "only" is misplaced here. What could explain the fact

that individuals who claim humanitarian goals would nevertheless shy away from dealing with the disabled, retarded, aged, delinquent, or disturbed, humans obviously in need of compassionate care?

Elaborating the different value types by race-sex offers at least a partial answer. Apparently variables other than occupational values are at work in motivating expressed attitudes to rehabilitation clients. Within three of the four categories of occupational value, race-sex differences persist. Women and Blacks are more accepting than males and whites among those with high self-expression values, those with high people-oriented values, and among those who reject an easy, secure life career. Only the group expressing high extrinsic values, who give preference to pay and prestige as career goals, departs from the pattern, although the N's here are quite small and percentages may be idiosyncratic.

These findings suggest that the cultural stigma still attached to Blacks and females is operating, and opens these categories of potential manpower to working with the stigmatized. The notion that feelings of "that's all I can hope for" are operating is hinted by the general rejection of rehabilitation work among those who have set their sights on money and prestige.

Summary

The various specialty occupations dealing with the rehabilitation of the disabled, retarded, disfigured, emotionally disturbed and socially disadvantaged have for a number of years suffered a manpower shortage. Despite current high unemployment rates, there is a likelihood that the need for more than double the number of 1970 workers by 1975 will not be met, in part because rehabilitation clients are stigmatized as unpleasantly different, and dealing with them is therefore considered "dirty work." Although there is

a recognized necessity for management of the deviant, and the positive aura of wide government and public support, rehabilitation workers as agents of social control are still difficult to recruit because of the dirty work stigma. Data from a sample of rehabilitation counselors show that even some of these workers agree that clients are physically unpleasant, while persons who have a disability are over-represented in this occupational group. Data from a sample of college students reveal variations in possible acceptance of rehabilitation clients on the basis of sex, race, and occupational values with females, Blacks, and those with people-oriented values the most accepting.

Implications

Data on counselors in the rehabilitation work system and individuals who are potential recruits for careers in the field support the notion that in this Age of Aquarius there is still widespread stigmatization of disability as deviance, and dealing with those in need of rehabilitation is "dirty work." An essential question is how can this "fact" be addressed in the context of improving the quality of service provided to those in need of rehabilitation? One solution is to turn to people previously squeezed out of the system. Six years ago,[6] over 80 percent of rehabilitation counselors were males, and over 90 percent white. Thus intensified recruitment efforts to obtain women, Blacks, Chicanos and other minorities, physically disabled, and retirees to work with victims of stigmatized social categories, can tap a manpower pool which has suffered because of its own departure from stereotypical norms. Recruitment should extend beyond token efforts and in time such workers, as they increase in numbers within rehabilitation work structures, can organize around themes of stigma reduction.

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The utility of this proposal is based on the continued difficulty faced by competent disabled, minorities, women and others viewed as deviant, in finding work. Long victims of the imputation of deviance, such persons can more readily identify with their patients and clients, and yet are protected from over-identification by the process of relative deprivation. They are sensitized to the troubles, frustrations and deprivations of the disstressed and stigmatized, but feel better off than their charges because of their professional or paraprofessional roles and associated prestige and power. Although the establishment may co-opt some, many of these new workers recruited from the ranks of the disadvantaged can function as linkers between the disabled and the human service and work systems of the society.

A sufficient reduction in the intensity and scope of labelling individuals may never occur in this society so as to provide the same number of options to the deviant and non-deviant. Such differential treatment is probably endemic to the functioning of complex societies. Where societies do vary is in the numbers, types, forms and consequences of labelling. Historical events, for example the disablement of Governor Wallace, can change public exposure to and acceptance of departures from the physical norm. Social movements, such as Gay Liberation, or the organizations of former mental patients, are changing public viewpoints concerning deviations from so-called normal behavior. Furthermore,women, Blacks, and other minorities, in the past relegated to society's less prestigeful and lower paying dirty work jobs in hospitals, factories, prisons, and other enterprises, will not continue to look kindly on being wooed into still another stigmatized occupational specialty. In short, while opening up employment and training on an egalitarian basis can make some inroads on laborpower shortages in rehabilitation,

changes in cultural values in the direction of wider acceptance of differences are necessary for any long-term effects on the field.

The influx of new types of workers into rehabilitation, groups with experience in pressing for expansion of educational and occupational opportunity, can itself have a dramatic effect in the reduction of stigma. Organized to win public acceptance and recognition of their work, these new staff can become less agents of social control than agents of social change in bringing about a reordering of societal priorities and values with respect to stigmatized work.

FOOTNOTES

1. Erving Goffman, Stigma (Englewood Cliffs: Prentice Hall, 1964), pp. 4-5.

2. E. C. Hughes, Men and Their Work (Glencoe, Illinois: The Free Press, 1963), pp. 49-52. A discussion of this concept related to rehabilitation work is found in M. B. Sussman, "Occupational Sociology and Rehabilitation," in Sociology and Rehabilitation, edited by M. B. Sussman (Washington, D.C.: American Sociological Association, 1965), pp. 195-196.

3. An opposite response is pity and self-indulgence where the role taker assumes a superordinate status and attitude of "looking after my charges." Those with this orientation who are attracted into the field are responding to stigma the opposite from avoidance. They behave as members of an upper caste which cannot enhance the opportunities of their patients or clients to become full participating members of the society.

4. These studies were supported in part by Rehabilitation Services Administration, Project No. RD-1726 and Project No. RD-3240. In the earlier study, 324 rehabilitation counseling students and 888 rehabilitation counselors and supervisors were surveyed. In 1970, 812 students in the metropolitan junior college and state university responded.

5. Morris Rosenberg, Occupations and Values (Glencoe, Illinois: The Free Press, 1957).

6. Marvin B. Sussman and Marie R. Haug, The Practitioners: Rehabilitation Counselors in Three Work Settings. Working Paper No. 4, Western Reserve University, Cleveland, Ohio, 1967.

Table 1

Manpower Needs: Skilled Occupations and Professions in Rehabilitation

Occupational Title	1970 Employment	1975 Estimated Employment Needs
Rehabilitation Counselors	13,400[a]	28,400[a]
Occupational Therapists	11,000[a]	23,000[a]
Physical Therapists	16,000[a]	36,000[a]
Speech Pathology and Audiology	13,000[b]	28,900[b]
Orthotics and Prosthetics	4,800[a]	9,000[a]
Recreation Therapists	6,000[a]	10,500[a]
Physical Medicine and Rehabilitation (M.D.)	1,200[a]	3,000[a]
Rehabilitation Nursing	600[a]	1,800[a]
Social Work (Medical and Psychiatric)	[25,500][c]	[25,500][d]
Rehabilitation Psychologists	1,000[a]	[1,000][d]
Totals	68,500	167,100

Sources:

a. Overview of the Training Grant Program of the Rehabilitation Services Administration Final Report of Study Project, SRS, No. 70-56, Socio-Technical Systems Associates, August, 1971.

b. Health Manpower Source Book Section 21, Allied Health Manpower, 1950-1980, U.S. Department of HEW, Public Health Service, NIH, U.S. Government Printing Office, 1970.

c. Health Resources Statistics, U.S. Department of HEW, Public Health Service, HSMHA, February, 1972. This may be an over-estimation of Social Workers actually in rehabilitation settings.

d. Since no estimates of 1975 needs in rehabilitation are available, 1970 employment figures are used.

Table 2

Rehabilitation Counselors (Trainees and Practitioners)
Attitudes on and Experiences with Disability

Attitudes and Experiences	1965 Graduating Trainees (N=324) %	1966 Practitioners (N=888) %
Percent agreeing that rehabilitation counselors must deal with physically unpleasant people	32	21
Percent agreeing that work as a rehabilitation counselor is often emotionally exhausting	68	66
Percent agreeing that most people would rather not be around anyone that is noticeably disabled	64	32
Percent with personal disablement	23	21
Percent with disability in immediate family	25	22
Percent with no prior experience with disability	28	69

Table 3

1970 College Students'
Race and Sex, and Rejection of Rehabilitation Clients

Race and Sex	Percent rejecting work with rehabilitation clients %	
Black Males	40	(53)
Black Females	25	(163)
White Males	58	(322)
White Females	29	(264)
Total	40	(802)

Table 4

1970 College Students'
Career Expectations and Rejection of Rehabilitation Clients

Career Expectations [a]	Percent Rejecting work with rehabilitation clients	
	%	
Scientific	50	(38)
Engineering	70	(37)
Business	55	(226)
Education	38	(180)
Law	25	(16)
Social Work	12	(92)
Medicine	21	(24)
Nursing	18	(89)
Public Administration	62	(16)

a. Career goals expressed by 15 or fewer respondents are not included in this table, e.g. architecture, agriculture, communications, etc. (N not included = 94)

Table 5

1970 College Students' Occupational Values,
by Race and Sex, and Rejection of Rehabilitation Clients

Occupational Values	Percent rejecting work with rehabilitation clients				
	Total	White Male	Black Male	White Female	Black Female
	% (N)	% (N)	% (N)	% (N)	% (N)
High Self-Expression Values[a]	48(236)	63(120)	40 (15)	39 (66)	13 (32)
High People-Oriented Values[b]	26(331)	31 (65)	50 (14)	23(167)	24 (78)
High Extrinsic Values[c]	62 (98)	66 (62)	50 (14)	100 (4)	50 (18)
Rejects life career in a secure, not too difficult job	29(396)	50(137)	36 (22)	17(153)	13 (81)

a. Combination of first, second or third choice to preference for jobs with "opportunity to use my special abilities and talents" and "permit me to be creative and original."

b. Combination of first, second or third choice to preference for jobs with "opportunity to work with people" and "opportunity to help others."

c. Combination of first, second or third choice to preference for jobs with "chance to earn good deal of money" and "social status and prestige."